The London Hospital Medical College

HOW TO TAKE HISTORIES

AND

EXAMINE MEDICAL PATIENTS

A SUMMARY FOR BEGINNERS

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[ca-1938?]

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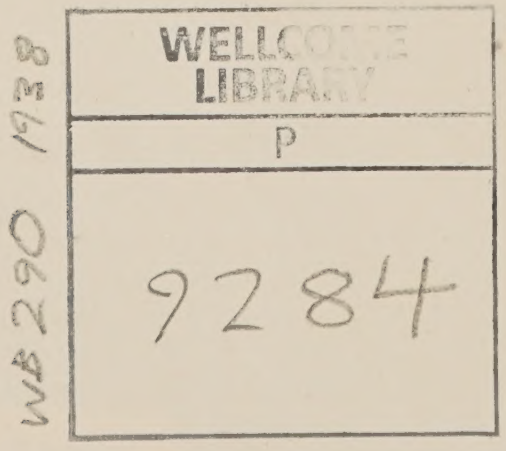
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I. INTRODUCTION.

When you go to the bedside of your patient do not begin by reading the diagnosis written on the Blue Board. Avoid reading the history and physical examination already written out by the House-Physician. Do not immediately hunt for the Out-Patient notes. Do not turn immediately to X-ray Films and Clinical Laboratory Reports. If you want to learn, take your cases "blind" and do not be afraid of making mistakes at first.

Remember that the patients allotted to you while you are acting as a Clerk or Dresser in the Wards will make a far more lasting impression on you and teach you much more than the spectacular cases of which you may obtain a fleeting glimpse at rounds and demonstrations. You must spend time over your cases, get them into your head, and know everything about them. It is not good enough to write the history and examination down on paper and then forget all about the case.

A good case record is one that combines accuracy and attention to detail with clarity and conciseness. A proper balance will be more easily established if the student realises that accurate information can seldom be obtained without patience, while patience should never be required of the person who is to read the case report.

In the following outline the methods of obtaining the history and performing the physical examination are described. The methods of writing out the history and the results of the physical examination are described separately.

II. TAKING THE HISTORY.

A. PRELIMINARY.

Remember that patients may be nervous on admission to Hospital. On first going to the bedside, therefore, a student should talk to the patient generally for a few minutes in order to gain his confidence. Then ask the patient his age and occupation. Ask him of what he is complaining, and let him talk with a minimum of interruption for a minute or two. This will give the student a rough impression of the history, and will also allow him to size up the intelligence and mental state of the patient. Sometimes the patient will have to be encouraged by leading questions, but more often tact will be required to confine his conversation to the present illness.

B. HISTORY OF PRESENT ILLNESS.

Now obtain an accurate history from the patient, taking pencil notes of dates, etc. It is important to get the history in outline before starting to write it out in detail, because almost invariably the patient leaves out something important when he is first asked to tell his own story. Define the onset of the present illness. The patient usually dates the start of his illness from some impressive event or from the onset of some severe symptom. Questioning will sometimes reveal earlier symptoms which belong to the history of the present illness. The real date of onset can often be more accurately defined by asking such questions as "When were you last quite well?", "Did you ever have a pain like this before?", or "Up to this time were you perfectly well?". It should be clearly stated whether the onset was sudden or gradual. Remember that in asking a question the answer should never be suggested.

Having established the time of onset, proceed to bring the history up to date. Patients usually classify and describe their symptoms according to severity, whereas in a case report they should be placed in chronological order. Any change in the severity of a symptom should also be described chronologically. There should be no ambiguity as to the fate of any symptom that is mentioned: its progress up to date should be described, or, if it disappeared and did not recur, this should be stated.

The voluntary statement of a patient as to the character of a symptom must usually be amplified. It is well to develop a routine questionnaire for some of the more common symptoms, although of course the routine will often have to be modified to fit the case, and experience alone can really teach the questions

to be asked. The following are the more common symptoms of disease which require special description, taken in alphabetical order :—

(1) **Cough :**

Character :—" Tickle in throat " or " from chest " ; painful or " easy ".

Sputum :—From " throat " or " chest " ; quantity ; colour ; hæmoptysis ; odour ; viscidity.

Time :—Continuous ; intermittent or paroxysmal ; association with seasons, or time of day or night.

Contributory causes :—Colds ; exercise ; posture.

Associated phenomena :—Wheezing ; pain ; vomiting.

Procedures which relieve the cough.

(2) **Diarrhœa :**

Character :—Urgency ; incontinence.

Stools :—Consistency ; colour ; odour ; mucous ; blood.

Time :—Frequency.

Associated phenomena :—Pain ; tenesmus ; sensation that emptying of the rectum is incomplete.

(3) **Dyspnœa :**

Character :—Wheezing or just " short of breath ".

Time :—Continuous, intermittent or paroxysmal ; association with seasons, or time of day or night.

Contributory causes :—Exercise (quantitative statement of amount of exercise required to elicit dyspnœa) ; coughing ; excitement ; posture—orthopnœa ; pain.

Associated phenomena :—Wheezing ; pain ; palpitation ; or other symptoms.

Procedures which relieve dyspnœa.

(4) **Indigestion :**

Character :—Loss of appetite ; flatulence ; heartburn ; regurgitation ; feeling of fullness ; nausea ; vomiting ; abdominal pain.

Association with seasons, certain foods, meals, constipation, habits and other symptoms.

Procedures which relieve indigestion.

(5) **Œdema :**

Distribution ; variation with time of day or exercise ; quantitative estimate (*e. g.*, " stocking and edge of shoes leave mark on skin ", or " shoes feel tight ", or " unable to put on shoes ", etc.).

(6) **Pain :**

N.B.—*The most important thing about pain is to find out what tends to bring it on,* i. e., *to what it is related,* e. g., *exertion, eating, muscular movements, etc.*

Character :—Knifelike ; stabbing ; colicky ; aching ; gnawing ; dragging ; is it real pain or merely discomfort ?

Situation :—Site of maximum intensity ; distribution ; radiation.

Time :—Continuous or intermittent ; interval between attacks ; duration of attack ; relation to seasons or time of day.

Severity :—Does it double him up ? Degree of incapacity.

Contributing causes : } Questions asked will depend on
Associated phenomena : } system involved.

Procedures which relieve pain.

(7) **Palpitation :**

Frequency and duration of attacks ; relation to exercise, meals, and other symptoms ; sensation of dropped beats.

(8) **Vomiting :**

Character :—Effortless ; regurgitant ; projectile ; self-induced ; nausea ; straining.

Vomitus :—Quantity ; colour ; constituents ; hæmatemesis.

Time :—Frequency ; time of day or night.

Contributory causes :—Meals ; coughing ; exercise ; etc.

Associated phenomena :—Pain ; sweating ; shivering ; etc.

Relief of other symptoms by vomiting.

When it is considered that a complete history of the present illness has been obtained, the patient should be subjected to a brief questionnaire on the functional changes which might be expected to occur with lesion of the various systems. The object of this questionnaire is to exclude the omission of symptoms which the patient has forgotten or has not considered worthy of mention.

General :—Loss of weight ; loss of energy ; night sweats.

Respiratory system :—Cough ; dyspnœa.

Cardiovascular system :—Dyspnœa ; pain ; palpitation ; œdema.

Alimentary system :—Appetite ; indigestion ; frequency of action of the bowels.

Urinary system :—Frequency ; difficulty or pain on micturition.

Nervous system :—Pain ; loss of power ; defective vision or hearing ; headache ; memory.

Skin :—Eruptions ; jaundice.

Locomotor system :—Pain or swelling in joints ; stiffness.

C. PREVIOUS HEALTH AND HABITS.

Having obtained as complete a history as possible of the present illness, the student should proceed to enquire into the previous illness and habits of the patient.

(*a*) Previous Health.

The age of the patient at the time of any previous illness should be recorded. With the exception of the exanthemata of childhood the patient's own diagnosis, or even that of a doctor or hospital, of a malady should never be uncritically accepted. It should be ascertained by whom the diagnosis was made and should be confirmed by a few questions on the symptoms experienced. If it is considered that the illness could in any way affect his subsequent health, or have any bearing on his present illness, these symptoms should be recorded in brief. In all cases the patient should be questioned specifically for a history of scarlet fever, tonsilitis, rheumatic fever, chorea, diphtheria, and exposure to tropical disease. Adult males should be questioned for a history of gonorrhœa or syphilis and their treatment. Women should be questioned on such physiological events as puberty, menstruation, pregnancies, miscarriages, and the menopause.

(*b*) Occupation.

The conditions of the present and previous occupations should be described if likely to have any bearing on his general health.

(*c*) Habits.

Alcohol ; tobacco ; regularity of meals ; sleep ; interests. Try and discover the kind of life the patient lives, his or her environment, hopes, fears, and circumstances.

D. FAMILY HISTORY.

The health of the following should be enquired into :—

Father and mother ;
Brothers and sisters ;
Wife or husband ;
Children.

If dead, the cause of death should be ascertained.

III. WRITING OUT THE HISTORY.

In the majority of cases the history should now be written out in detail. If, however, the student is not satisfied with the coherency or accuracy of the history obtained, he may with advantage postpone the writing of the history until the physical examination has been completed. This may give indications for asking further questions, which may result in supplementing or clarifying the history.

In writing the history the following form should be adhered to :—

The patient's full name, surname first.

Age.

Sex.

Married or single.

Occupation, with details if necessary.

Name and address of nearest relative.

Name and address of private doctor.

Admitted under Dr. ..... on.....

to.....Ward.

Complaints.—The symptoms of which the patient complains should be stated in brief. The object of this heading is to provide the reader with a clear conception of what made the patient seek medical advice. The complaints should be written more or less in the patient's own words, but should be abbreviated

in telegraphic style. The approximate duration of each complaint should also be stated: *e. g.*, shortness of breath for 5 years, or, pain in the chest for 2 days. It is seldom that this section should occupy more than three or four lines.

History of present illness.—The importance of an accurate definition of the onset and of the arrangement of symptoms in chronological order has already been emphasized. A correct appreciation of the progress of symptoms can usually be facilitated by starting a new paragraph whenever there appears to be some definite change in the course of the patient's illness. These paragraphs should start with some precise statement of the passage ot time, such as " Fourteen years ago, at the age of 8 ", or " Twelve hours later . . . .". Telegraphic style is to be avoided, and an effort should be made to give as readable an account as possible without entering into unnecessary detail. When the history has been completed brief mention should be made of the absence of any symptoms which might have been expected to occur. For instance, if the history suggests cardio-vascular disease, the absence of such symptoms as dyspnœa, palpitation, pain, etc. should be mentioned.

If, in the course of the present illness, the patient has been previously admitted to the London Hospital, a statement to this effect should be made. A synopsis of the findings on the previous admission must be made at the *end* of this case report, after the physical examination has been described.

Previous health.—Any previous illnesses which might affect the subsequent health of the patient, or have an indirect bearing on the present illness, should be described. Those with a direct bearing on the present condition should be described in the history of the present illness, *e. g.*, acute rheumatism in childhood and heart failure in adult life, or primary syphilis in youth and aortic aneurysm at the age of 60. The description should be in sufficient detail to indicate the possible after-effects. Other illnesses should merely be mentioned. The age of the patient at the time of any illness should be stated.

Occupation.—The present occupation should be stated. The conditions of the present and previous occupations should be described if likely to have any bearing on the general health of the patient.

Habits.—A brief account should be given of the kind of life the patient leads. Something should be said of his environment and circumstances. The consumption of alcohol and tobacco, and the regularity or otherwise of the bowels, should always

be stated. Any other habits or irregularities in the daily routine which might have a bearing on the general health of the patient should be described.

Family History.—Brief mention should be made of the following :—

Number of children, and brothers and sisters, who are alive and well.
Health of wife or husband.
Cause of death in any members of the family.
Miscarriages.

IV. THE PHYSICAL EXAMINATION.

In performing a physical examination it is essential to develop a routine which will combine thoroughness with speed and a minimum of discomfort to the patient. These conditions are best satisfied if the patient is examined from the head downwards, without any attempt at isolation of the systems. The following is an outline of the examination which should be performed in all cases. Written in *red* are the special forms of examination which need only be performed if there is some specific indication.

A. MENTAL STATE.

If the history has been taken with intelligence, the examination of the mental state has for the most part been performed. The following points should be noted :—

General behaviour :—Appearance, manner, and general impression.
Intelligence :—General and educational achievements.
Emotional state :—General mood ; emotional reactions and their relation to the present illness.
Speech and articulation.
(*Mental con'ent :—Mental problems and conflicts ; scope of interests.*)

B. GENERAL CONDITION AND APPEARANCE.

Temperature.
Decubitus (attitude of the patient).
Expression :—Cheerful or morose ; healthy or ill.
Build :—Plethoric ; asthenic ; etc.
Other morbid appearances.

The following are noted throughout the examination :—

The Skin.

Texture :—Atrophic or coarse.

Surface :—Smooth ; dry or moist ; sweating ; eruptions ; scars ; etc.

Colour :—Anæmia ; jaundice ; cyanosis ; pigmentation ; rashes.

Subcutaneous Tissues.

Emaciation ; obesity ; œdema ; nodules.

Lymph Glands.

Character of enlargement ; signs of inflammation ; etc.

Joints.

Swelling ; tenderness ; signs of inflammation ; crepitation ; limitation of movement (active and passive).

C. THE HEAD.

Eyes.

Exophthalmos ; ptosis ; œdema of lids ; pigmentation.

Conjunctivæ :—Anæmia ; jaundice ; corneal reflex.

Pupils :—Size ; equality ; regularity ; opacities ; reaction to light ; reaction to accommodation (third nerve).

Eye movements (third, fourth and sixth nerves) :—Strabismus ; nystagmus.

(*Special examinations :—Acuity of vision ; fields of vision; opththalmoscopic examination.*)

Face.

Function of seventh nerve.

(*Special examination :—Function of fifth nerve.*)

(*Special examination :—Transillumination of sinuses.*)

Ears.

Cyanosis.

Discharge.

(*Special examination :—Acuity of hearing (eighth nerve) ; examination of ear drum ; hearing (air conduction and bone conduction.*)

Nose.

Deformities.

Dilatation of alæ nasi on inspiration.

(*Special examination :—Nasal speculum ; function of first nerve.*)

Scalp.

Texture of hair.

Seborrhea, etc.

Mouth and Pharynx.

Breath :—Odour.

Lips :—Anæmia ; cyanosis ; herpes ; sordes.

Tongue :—Protrusion (twelfth nerve) ; tremor ; colour ; coat ; dry or moist ; papillæ ; ulceration.

Teeth :—Caries ; dentures.

Gums :—pyorrhœa ; hæmorrhage ; sordes ; pigmentation.

Buccal mucous membrane :—Ulceration ; pigmentation.

Palate :—Anæmia ; jaundice.

Pharynx :—Movement of soft palate (tenth nerve) ; inflammation ; tonsils ; palate reflex.

(*Special examinations :—Function of ninth nerve ; function of sensory branch of fifth nerve ; examination of vocal cords.*)

D. NECK.

Symmetry ; swellings ; pulsations (arterial or venous) ; venous engorgement ; lymphatic glands.

Thyroid gland :—Inspection ; palpation.

E. UPPER LIMBS.

General Inspection.

Skin ; subcutaneous tissue ; joints ; deformities ; vasomotor changes.

Fingers.

Cyanosis ; clubbing ; tremor.

Hands.

Wasting of small muscles.

Pulse.

Rate ; rhythm ; volume ; tension ; arterial wall ; comparison with other side.

Axillæ.

Lymphatic glands.

(*Special examinations :—Function of individual muscles, or muscle groups ; biceps, triceps, and supinator jerks ; fibrillation ; coordination ; adiadokokinesia.*

Sensory function :—Tactile sensibility ; sensibility to pain ; thermal sensibility ; sense of position ; stereognosis ; tactile discrimination.)

Blood pressure.

(*Special examination :—Bilateral B.P. measurement ; capillary pulsation.*)

F. THE THORAX.

(1) **Anteriorly and Laterally.** (Patient recumbent.)

Inspection.

Type of chest :—Alar ; barrel-shaped ; rickety ; etc.

Asymmetry :—Flattening ; bulging.

Rate, depth, and character of breathing.

Respiratory movements (both with ordinary inspiration and full inspiration) :—Asymmetrical expansion ; paradoxical movements.

Pulsations (including any at root of neck and in epigastrium) :—Character ; distribution.

Dilated vessels.

Palpation.

Localization and definition of apex beat.

Palpation of all visible pulsations :—Distribution ; force ; thrills.

Position of trachea.

Palpation of chest expansion.

Vocal fremitus.

Percussion.

If the apex beat cannot be felt try and define the position and size of the heart by percussion.

Percussion of lungs.

Auscultation.

Heart sounds :—Intensity ; rhythm ; quality ; murmurs ; pulse deficit.

Breath sounds ; adventitious sounds (with and without forced inspiration and after coughing).

Vocal resonance ; whispering pectoriloquey.

(2) **Posteriorly.** (Patient sitting.)

Inspection.

Spinal deformity; wasting of the trapezii muscles; expansion of apices.

(*Special examination :—Measurement of total chest expansion and of expansion of two sides separately.*)

Palpation.

Palpation of chest expansion.
Vocal fremitus.

Percussion.

Of lung.

Auscultation.

Breath sounds; adventitious sounds (with and without forced inspiration and after coughing).

Vocal resonance; whispering pectoriloquey.

(*Special examinations :—Tidal percussion at bases; coin percussion; succession splash; motor functions of thoracic musculature; sensation.*)

G. SPINE AND LOWER PART OF BACK.

Deformity.
Tenderness of spine.
Œdema of lumbar region.

H. ABDOMEN.

Inspection.

Size; contour; distension; symmetry; movement of abdominal wall; dilated vessels; umbilicus; visible peristalsis; pulsations.

Palpation.

Tenderness; rigidity; hyperæsthesia; increased resistance to palpation; abdominal masses; splashing.

Hernial orifices :—Impulse on coughing.

Inguinal glands.

Individual viscera.

Liver and spleen :—Attempt at palpation; percussion.

Kidneys :—Attempt at palpation; tenderness in renal angle.

Stomach :—Attempt at palpation; note splashing.

In men :—Penis and scrotum : scars ; discharge ; epididimis ; spermatic cord ; testis ; examination of prostate per rectum.

In women :—Uterus and appendages by abdominal palpation.

(*Special examinations :—Examination per vaginum (only with permission of First Assistant) ; for ascites (percussion and transmitted thrill) ; sensory function of abdominal wall ; motor function of abdominal musculature ; abdominal reflexes.*)

I. THE LOWER LIMBS.

Gait.

General Inspection.

Skin ; subcutaneous tissue ; joints ; deformities ; vasomotor changes ; œdema ; clubbing of toes.

Reflexes.

Knee jerk ; ankle jerk ; plantar.

(*Special examinations :—Function of individual muscles, or muscle groups ; fibrillation ; coordination ; clonus.*

Sensory function :—Tactile sensibility ; sensibility to pain ; thermal sensibility ; sense of position ; vibration sense ; tactile discrimination.

Palpation of femoral and dorsalis pedis arteries ; femoral blood pressure.)

J. EXAMINATION OF EXCRETA.

(1) **Urine.**

Colour ; reaction ; specific gravity ; albumen ; sugar ; Guiac test ; deposit. If albumen is present, boil $\frac{3}{4}$ of a test-tube full and place the tube over the bed. Centrifuge another sample and examine it microscopically in the clinical laboratory for blood, pus and casts.

(2) **Sputum.**

Quantity per diem ; odour ; colour ; consistency or viscidity ; blood ; froth ; layers.

(3) **Stools.**
(4) **Vomitus.** } Inspect if specimens have been put in the test room.

V. WRITING OUT THE PHYSICAL EXAMINATION.

Although the physical examination is performed "geographically", the findings must be recorded according to systems. The general appearance of the patient should always be first described. Thereafter the order in which the systems are dealt with will vary with the individual case. The system which shows the most significant findings should be described first.

In the absence of any morbid signs it is not necessary to record every step of the physical examination. Certain items, however, should always be mentioned. In the following scheme a description of a hypothetical case with no abnormal physical signs is given. This description represents the minimal statement which must be made in a perfectly healthy subject.

A. GENERAL.

General appearance :—Indicate how ill the patient looks and any other general signs, such as restlessness, dyspnœa, orthopnœa, stupor, etc.

State of nutrition.

Temperature.

Tongue and condition of mucous membrane.

Teeth, gums and buccal mucous membrane :—General estimate of condition.

Fauces :—Condition of tonsils and pharynx.

Anæmia of skin or mucous membranes.

Jaundice of skin or mucous membranes.

Cyanosis of skin or mucous membranes.

Lymphatic glands :—Describe in same order as examined.

Thyroid gland.

Skin.

Œdema.

Clubbing of fingers.

Joints and bones.

Minimal Statement where no morbid signs are present.

Healthy-looking, well-nourished man.

Temperature 98·2.

Tongue clean and moist.

Teeth and gums healthy.

Fauces :—Tonsils not enlarged ; throat not inflamed.

No anæmia of skin or mucous membranes.
No cyanosis.
No jaundice.
No enlargement of lymphatic glands.
Thyroid not enlarged.
No œdema.
No clubbing.

B. CARDIOVASCULAR SYSTEM.

Pulse :—A full description.
Condition of other arteries.
Venous engorgement.
Pulsations and their character.

Heart :—Position of apex beat and its character ; percussion of cardiac borders if the apex beat was not palpable ; character and intensity of heart sounds ; murmurs and their propagation ; pulse deficit.
Blood pressure.

Minimal Statement where no morbid signs are present.

Pulse :—Rate 72 ; regular ; no thickening of arterial wall.
Apex beat :—5th space $\frac{1}{2}''$ internal to M.C.L. (or $3\frac{1}{2}''$ from mid line).
No evidence of cardiac enlargement.
Heart sounds.—1 and 2 heard in all areas ; no murmurs.
B.P. $= \frac{120}{80}$.

C. RESPIRATORY SYSTEM.

Respiratory rate.
Dyspnœa ; orthopnœa.
Position of trachea.
General type of chest.
Shape of chest ; symmetry.
Expansion of chest ; symmetry.
Mensuration of chest and expansion.
Palpation, percussion and auscultation :—If morbid signs are present these should be grouped according to the area of the chest wall over which they have been elicited. In defining these areas the terms " supra-clavicular ", " infra-clavicular ", " axillary ", " supra-scapular ", " scapular ", " inter-scapular ", and " infra-scapular " or " base " may be

used. It is often better to define the area in terms of ribs or interspaces, stating whether it is the anterior, lateral or posterior aspect of the chest which is involved. The following vertical lines may be used if a more accurate definition is required :—" para-sternal ", " mid-clavicular ", " anterior axillary ", " mid-axillary ", and " post-axillary ". The nipple and the various bony landmarks may also be used. (It should be remembered that the position of the scapula varies with the position of the shoulder-joint.) Having defined the area in question, the physical signs elicited from the underlying lung should be described in the following order :—inspection, palpation, percussion and auscultation.

Sputum :—Quantity and character.

Minimal Statement where no morbid signs are present.

Shape :—Normal and symmetrical.

Movements :—Good and symmetrical.

No impairment of percussion note.

Breath sounds vesicular ; no adventitious sounds.

V.R. and V.F. normal.

D. ABDOMEN.

If morbid signs are present they should be described as best fits the case. The following order can usually be adhered to :—

Inspection :—Shape ; distension (general or local) ; movements with respirations ; venous distension ; umbilicus ; pulsation ; peristalsis.

Palpation and percussion :—Tenderness ; rigidity ; hyperæsthesia ; liver ; spleen ; kidneys ; any other abdominal masses ; stomach ; ascites ; hernial orifices.

Spine.

In men :—Genitalia ; rectal examination.

In women :—Uterus and appendages ; vaginal and rectal examination.

Stools.

Minimal Statement where no morbid signs are present.

Normal in shape.

Moves well with respiration.

No tenderness or rigidity.

Liver, spleen, and kidneys not palpable.

No ascites.

E. NERVOUS SYSTEM.

(1) General.

Mental state ; intellectual functions ; emotional stata ; speech and articulation ; gait.

(2) The Cranial Nerves.

In any neurological case a full description of the examination of the cranial nerves, taken in their order, should be given.

(3) Upper Limbs.

(4) Trunk.

(5) Lower Limbs.

Physical signs should be described in the following order :—

Wasting ; power ; tone ; coordination.
Sensory disturbances.
Reflexes.

Minimal Statement where no morbid signs are present.

Normal mentality and intelligence.

Pupils equal ; regular ; react equally to L. & A.

Eye movements not impaired ; no nystagmus.

Other cranial nerves normal.

K.J.'s and A.J.'s present and equal both sides ; P.R. flexor response.

E. URINE.

Colour ; reaction ; specific gravity ; sugar ; albumen ; Guiac test ; deposit (microscopic examination).

VI. PREVIOUS ADMISSIONS.

If the patient has been previously admitted to the London Hospital, the notes should be obtained from the Registrar's Office. An abstract should be made of the symptoms, physical findings, treatment, and course of the disease. The length of this abstract will vary with the individual case, but no item should be omitted that may have a bearing on the present illness of the patient.

VII. DIAGNOSIS.

In making a diagnosis the student should attempt to translate the symptoms and signs of disease in terms of

(1) The disorder of function,

(2) The structural lesion,

and (3) The pathological process.

He should first ask himself if his patient is suffering from any disorder of physiological function, and if so what function. Sometimes the signs and symptoms are the direct consequence of a disturbance of function of some individual organ. More often they are an expression of a pathological process affecting many of the organs. Having made up his mind as to the disorder of function, the student should decide whether or not there is sufficient evidence to warrant the diagnosis of a structural lesion Lastly, the student should think out the most probable pathological processes responsible for the disorder of function and the structural lesions. It must be remembered that the same disorder of function may be due to a number of quite different pathological processes. For instance, loss of voice may be due to catarrh, tuberculosis, syphilis, new growth, intrathoracic aneurysm, or hysteria.

The diagnosis should be written out in the reverse order, as this order gives the true sequence of events and the correct picture of the patient's condition, *i. e.*, thus :

(1) The pathological process,

(2) The structural lesion, if any,

(3) Disorder of function, if any.

The following are a few examples :—

(i) Chronic rheumatic carditis. Mitral stenosis. Auricular fibrillation. Myocardial failure.

(ii) Syphilitis aortitis. Aortic imcompetence. Occlusion of coronary arteries. Myocardial failure.

(iii) Meningo-vascular syphilis. Transverse myelitis of cord. Spastic paraplegia.

(iv) Meningo-vascular syphilis. Thrombosis of middle cerebral artery. Left spastic hemiplegia.

(v) Primary chronic nephritis. Uræmia.

(vi) Chronic duodenal ulcer.

(vii) Primary carcinoma of stomach. Pyloric obstruction.

(viii) Fibrosis of lung. Bronchiectasis.

It will be evident from the examples given that it is often impossible to give a diagnosis under all three of these headings.

A student having made a provisional diagnosis as he will have to do in general practice, should then write down the laboratory and X-ray examinations he considers necessary to establish a final diagnosis. These investigations are ordered by the House-Physician. When the reports of these investigations are sent to the Ward, it is the duty of the clerk to study them and copy the reports into his Progress Notes.

VIII. PROGRESS NOTES.

The writing of progress notes is an integral part of case taking. If the patient is in hospital for many weeks with little or no change in his clinical condition, a brief note will suffice. If the course of the disease is full of incident, daily notes should be made. In all cases a progress note must be written at least once a week, even if it is only to record no change in the patient's condition.

A student should make a particular point of ascertaining whether any minor operative procedure, such as lumbar puncture, aspiration of the chest, or an intravenous injection, is to be performed on any of the patients under his care. If so he should make special effort to be present when it is performed by the House-Physician. If he does this, he will probably be allowed in due course to perform one or more of these minor operations himself.

Should a student find that one of his patients is to be transferred to a surgical ward or some other department of the Hospital, he should continue to visit this patient in order to ascertain the patient's progress and be in a position to inform his Chief as to the progress of the patient. If an operation should be performed on one of his patients, he should endeavour to be present at the operation, and he should visit the patient afterwards in order to judge the results.

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